WISCONSIN

LONG TERM CARE

FUNCTIONAL SCREEN

INSTRUCTIONS

Department of Health and Family Services
Office of Strategic Finance
Center for Delivery Systems Development
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WISCONSIN LONG TERM CARE FUNCTIONAL SCREEN INSTRUCTIONS

During the Transition Period, 2000

The Federal Health Care Financing Administration must approve a new waiver for this screen to replace the current waiver eligibility forms such as the COP/W eligibility screen. We expect approval before January 1, 2001. Until then, the COP functional eligibility screen (and any other required forms such as CSLA level of care form) will determine waiver eligibility. Anyone who is waiver eligible by current methods will be considered Family Care Comprehensive level. After July 1, 2000, CMOs can enroll people who are Family Care eligible (per this screen) but not waiver eligible (per COP eligibility screen and other waiver eligibility forms).

In 2000, Resource Centers must complete currently required waiver eligibility screens and forms in addition to this LTC FS. We will compare the results of both in order to confirm that the LTC FS eligibility logic (which is programmed into the LTC FS computer application) works well.

For details on the other waiver eligibility documents required throughout 2000, please refer to the waiver simplification memos of February 2000.

Overview of the Long Term Care Functional Screen

The Wisconsin Long Term Care Functional Screen (LTC FS) will determine a person's eligibility for Family Care and access to Wisconsin's home and community based waiver services under a managed care contract. Family Care is an entitlement, so the screen will be determining entitlement to Medicaid funded services. This mandates special requirements for quality assurance and screener qualifications.

The LTC FS was designed to work for the intended Family Care populations or "target groups": frail elders, adults with physical disabilities, adults with developmental disabilities, people with Alzheimer's or other irreversible dementia, and adults with terminal conditions (defined as life expectancy one year or less from date of functional screen). The LTC FS will:

1. Determine an individual's functional eligibility for Family Care: Comprehensive level, Intermediate level, or functionally ineligible.
2. Determine an individual's level of care for nursing home or ICF/MR
3. Provide a framework for information-gathering during Pre-Admission Counseling
4. Serve as a foundation for the comprehensive assessment to be done by the Care Management Organization (CMO). (The screen will be passed on to the consumer's chosen CMO.)
5. Provide data for quality assurance and improvement studies for DHFS, CMOs, and Resource Centers, including identifying cases for targeted reviews.
6. Identify whether person is currently in need of Adult Protective Services—a factor that affects entitlement for persons at Intermediate level.
7. Indicate the need for referrals to Adult Protective Services, mental health services, substance abuse services, or other community resources.
8. Be used (after more research) to set monthly payment rates to the CMO based on people's functional needs.

9. Document factors for Resource Centers to prioritize waiting lists.

The screen has six modules:

I. Demographics
II. Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)
III. Diagnoses and Health-Related Services
IV. Cognition and Communication
V. Behaviors/ Symptoms
VI. Risk

A person's screen will be taken **in total**. A complex computer program has been developed to "weigh" all clinical factors in ways that reflect likely needs. The Risk Module plays an important role in how a consumer's screen works in total. The Risk Module was specifically developed to be able to "capture" people who might be independent in ADLs and IADLs and without any cognitive impairments—but still at risk. (So screeners should never "inflate" their answers in other modules to compensate for risk factors; screeners can document risk factors in the Risk Module.)

The screen does ask information on the consumer's current supports, including informal supports. This information has no impact on the consumer's eligibility for Family Care or any other program. It is for research only (to help make sense of actual LTC costs).

The LTC FS in Context of Resource Centers' Services

Administering the functional screen is only one of the Resource Centers' many responsibilities. Resource Center (RC) staff will also counsel people on all their long term options (on where they could live, what services and providers they could have, etc.). Resource Centers will be also responsible for information and assistance, early intervention and prevention, and informing the public about community resources both within the LTC system and beyond it.

The LTC FS does not come first in the process of serving people. First, RC staff would talk with the consumer and others to ascertain the situation and needs and to find out what they are interested in. The RC staff needs to interact with the consumer and discover enough about her or him to get impressions about appropriate options. In most cases, this interaction is needed before the screener could answer the target group question on the LTC FS.

The LTC FS Is Voluntary

Family Care is a voluntary program. Consumers must consent to having the LTC FS completed in order to enroll in Family Care. In Resource Center pilots without CMOs, the LTC FS is for research only. (Those counties will be a "control group" against CMO counties to evaluate the effects of Family Care.) The person being screened should consent to completion of this screen and its submission to DHFS for aggregate data research. No screen should be completed without the person's consent.

The Resource Center shall comply with confidentiality rules and requirements and shall obtain a signed release of information from the person or the person's guardian or power of attorney, where applicable, for the use of medical records, educational records and other records as appropriate before conducting the LTC Functional Screen and COP Functional Screen. Signed releases of information shall be included in the person's records at the Resource Center when appropriate.

Confidentiality

Any information collected for the screen or during the screening process is **confidential**. It is to be treated with the same requirements for confidentiality as other longstanding screens and

assessments. If a person enrolls in a CMO, the functional screen can be shared with the CMO without separate written permission.

Screening and Re-Screening Requirements

The LTC FS will be done annually for people who choose to enroll in a CMO. (The CMO is required to contact the local Resource Center to request annual re-screens as needed.)
The LTC FS can be done more often than yearly if someone requests it. In particular, the screen could be done if the person's condition or situation changes in a way that might affect their eligibility. (Such a re-screening could be requested by the CMO or the person or other parties).
See Resource Center and CMO contracts for other screening requirements and timetables.

LTC FS and Pre-Admission Consultation

Please see other DHFS documents for statutory requirements and guidelines on Pre-Admission Consultation. As noted above, completion of the LTC FS is only one part of RC services. The screener will complete a LTC FS after developing an understanding of the person's situation and LTC needs and interests.

Screener Qualifications

All persons administering this functional screen must meet the following four conditions:

1. Be a public employee.
   This is federal law because the screen determines eligibility for federal programs (after 2000 as noted above).
2. Meet the following minimum criteria for education and experience:
   (i) Bachelor of Arts or Science degree, preferably in a health or human services related field, and at least one year of experience working with at least one of the target populations; or
   (ii) Prior approval from the Department based on a combination of post-secondary education and experience or on a written plan for formal and on-the-job training to develop the required expertise prepared by the Resource Center.
3. Meet all training requirements as specified by the Department.
   Currently the training requirements consist of attending a DHFS clinical/professional screen training. The only exception is that RC staff unable to attend a DHFS training can watch a DHFS screen training videotape. The video is an option only for employees of a county whose staff have attended a DHFS training and which has a "Screen Lead" staff person assigned to advise new screeners and ensure on-going quality assurance.
   All screeners should read the screen instructions as well.
   (See also Resource Center contract for quality assurance requirements.)
4. Pass a Screener Certification exam (a "post-test") after receiving training.

The Screening Process

The screening process requires face-to face contact with the individual being screened.
No screen should be completed without a meeting with the consumer, even if s/he is unable to communicate.

The Interview Process

This screen was not designed as an interview tool; screeners are expected to use their professional skills to adjust their interview style to the individual and the situation. The screen can be done in any order.

The face-to-face interview can take place in any setting, from the consumer's residence, to a substitute care setting such as a CBRF, to a hospital or nursing home. It may take more than one contact with the consumer to complete the screen.

Screeners should use their professional interviewing skills to gather information in a way that is appropriate for a given consumer. The screener will need to ask questions in a variety of ways, be familiar with the participant target group being interviewed, and use collateral informants as necessary. Collateral informants include family, significant others, formal or informal caregivers, health care providers, and agencies serving the consumer. The screener must always have a face-to-face contact with the consumer, even if other informants are used.

Reliability of Screen and Screeners

This screen has been repeatedly revised with users' input and statistically proven to have acceptable levels of validity and reliability. However, it is generally recognized that any objective rating of consumers' functioning, cognition, behavior and symptoms can be difficult. The difficulty calls for extra vigilance to ensure the greatest possible accuracy in the LTC FS. This is why screeners must be certified and why DHFS and Resource Centers must have on-going quality assurance processes. Screeners should adhere to the following guidelines:

- Read and follow screen definitions and instructions closely.
- Go slowly and carefully enough to be accurate even with someone you know well.
- Do not "inflate" any answers because you think a consumer has special costs not "visible" through the screen. Instead, you should always select the answer that most accurately describes the consumer's status.
- Refer all questions to your Resource Center's designated Screen Lead Staff.
  The screen lead in turn will refer questions to the Center for Delivery Systems Development. In this way, interpretations can be kept consistent and communicated to all Resource Centers, and revisions can be made to the LTC FS if necessary.

In particular, screeners should be aware of the following limitations found in national studies to be characteristic of all similar screens:

A. Health care and institutional providers tend to over-rate the consumer's dependency on others.
B. Guardians, spouses, and family members often tend to over-rate the consumer's dependency on others.
C. Consumers often under-rate their need for help from others and exaggerate their abilities.
D. Consumers' functional abilities can fluctuate, making it difficult to select a "best" answer.
E. Consumers can provide conflicting information at different times or to different screeners.
F. Screen answers vary somewhat depending on whether the screener knows the consumer well or not.
G. Screen answers vary somewhat depending on the profession of the screener.
H. While objectivity is strived for, some subjectivity may remain in some questions.

Strategies to minimize some of these effects are discussed in order below.

A and B: Conflicting Information from Different People

Sometimes screeners will get different information from different sources. Consumers may function less independently in day care facilities or institutions than they do at home, and staff at such facilities may tend to perceive more dependency than family or peers in the community might

perceive. Screeners are to use their best professional judgment to describe the person's functional abilities as accurately as possible given all the information from multiple sources. Keeping in mind the tendencies noted above, **the best source of information (besides the person themselves) is someone who does a lot of direct care for the person and likes her/him.** In a health care facility, the screener should (if collaboration is needed) talk to a nurses' aide, not just the nurses. In the home, a personal care worker might provide a more accurate description than family members.

C: Consumer Gives Apparently Inaccurate Information

Sometimes the consumer's statements about her/his abilities do not seem to cohere with reality. If you feel this is happening, follow this three-step process:

1. Seek more details.
2. Seek collateral informants, other people you could ask for additional information.
3. Use your professional judgement to select what seems to be the most accurate answers. follows the definitions and instructions for the screen.

Example: Bert tells you he doesn't need any help with bathing. He lives alone. He is unkempt and smelly. He walks very unsteadily with a cane, is bent over, and is unable to lift either leg off the floor when you ask him to. It's quite clear to you that he is not able to safely get into and out of his bathtub and that he in fact has not bathed for many weeks.

Step 1: Seek more details.

You ask him if you can see his bathroom, where you notice that he has a claw-foot bathtub with sides about 2 feet high off the floor (with no grab bars, bench, or non-slip mats).

You observe his ambulation and ask him to lift his foot high for you.

You ask him for details on how he gets in and out of the bathtub.

Step 2: Seek collateral informants.

Bert's daughter referred him to the Resource Center and is present during the screen interview. You speak to her privately on the way out to get her perspective on her dad's functioning. She says he's lying now because he's afraid, but he's admitted to her that he is unable to get into the bathtub.

Step 3: Use your professional judgement to select the best answer.

You can see from Bert's general body movement that he would need help with all aspects of bathing, not just getting in and out of the tub. For bathing you select box 2, "Helper needs to be present throughout the task."

D. Abilities Fluctuate

Some similar screens or data collection instruments like the Minimum Data Set (MDS) required of nursing homes and the OASIS (required of home health agencies) were designed to provide a "snapshot" view of functional status. So their questions ask, for example, for functioning in the past 7 days, or over the past month. The LTC FS provides a broader view to more accurately reflect an individual's likely long term care needs. We realize that many long term care consumers have conditions and abilities that fluctuate over time, and that it is sometimes difficult to choose the best "multiple choice" answer. In completing the screen, please follow the following guidelines:

- If the person's functional abilities **vary over months or years**, select the answer that seems closest to the average frequency of help needed.

  Example: Bob works independently at his job except for emotional "flare-ups" about once or twice a year, when he requires interventions several times a week for two or three weeks. Under the question on Employment Assistance, you would select box 1, "Needs help monthly or less."

- If the person's functional abilities **vary <u>day to day</u>**, select the answer that most accurately describes their needs on a "bad" day.
  Example: Mary has multiple sclerosis. Her strength varies day to day and even hour to hour, depending on humidity, heat, fatigue, and stress levels. Sometimes she can transfer herself, but she generally needs help. Since staff cannot know when she'll have stronger moments, they are available for all transfers. Select the answer that reflects that higher frequency.
- If the person's functional abilities **vary <u>week to week</u>**, try to select answers that reflect how you would staff them if you had to.

Screening During Acute Episodes

The LTC FS will be completed as part of pre-admission counseling when consumers enter nursing homes and residential facilities. Approximately 70% of people enter nursing homes from hospitals. It is expected, then, that some LTC FS will reflect higher needs due to more acute conditions and that many people may improve over the next several days, weeks, or months. Their improvement will be evident in their next LTC FS.

Impending Discharge

When doing the LTC FS on someone preparing for discharge from a skilled health care facility, complete the screen based on how the person would function at home when they go home. This looking ahead is a normal part of discharge planning. So, if, for example, oxygen and intravenous (IV) will be stopped before person goes home in two days, do not mark them on the screen. If family is learning to do a 2-person pivot transfer to prepare to use at home, mark that on the screen, even if now the hospital does one-person transfers with a mechanical lift. It will take additional time and talking with facility staff, family, etc., to get the most accurate picture of the person's needs at home, after discharge.

The screener must be able to envision the person at home. This is why screeners must have experience in community care for the target group being screened.

Verifying Diagnoses and Health-Related Services

The Health-Related Services table is extremely important to determining a person's eligibility. The table is objective data for programmed logic to determine whether the person meets nursing home or ICF-MR level of care, which in turn determines eligibility for home and community-based waivers (to generate federal waiver funds) and affects the Family Care eligibility (Comprehensive vs. Intermediate). Accuracy in this information will be a focus in quality assurance and improvement efforts both locally and at the DHFS. The diagnoses will provide important data for evaluating Family Care, but do not have direct role in the eligibility logics. The target group question (discussed in detail below) may require help from health care professionals as well.

No health care providers' signatures are required on the screen, but screeners must take the time to verify health-related information. Screeners will need to verify diagnoses and health-related services for the LTC FS, and can verify information needed for the target group question at the same time. Explain this to the person, and either get permission to contact their physician's office or help arrange an appointment.

IN ALMOST ALL CASES, SCREENERS WILL NEED TO CONTACT A HEALTH CARE PROVIDER TO GET ACCURATE INFORMATION ON HEALTH-RELATED SERVICES DIAGNOSES, AND, IF NECESSARY, THE TARGET GROUP QUESTION.

Target Group Question

Eligibility for Family Care is for people who have "a long-term care condition which is expected to last for more than 90 days related to infirmities of aging, physical disability, developmental disability, dementia (onset of any age), or a terminal condition with death expected within one year from the date of the eligibility for long-term care services."

This breaks into three steps:

First, person must have a long term care condition expected to last more than 90 days or result in death within one year.

Second, person must be in one of the populations or "target groups" intended for Family Care.

Third, person in a target group must have ADL/IADL deficits specified for Family Care eligibility.

This means three things:

1. A person could be temporarily "physically disabled" but not have "a long term care condition expected to last more than 90 days…"

   Example: Healthy 60 year old woman with recent hip fracture is in nursing home for brief rehabilitation. She was completely independent before the fracture. She is expected to recover completely within 2 months and to have no long term care conditions after that.

2. A person could be in a target group but not eligible for Family Care –if s/he does not have any ADL/IADL deficits.

   Example A: Person has a diagnosis of a terminal condition, but currently needs no help with any ADLs/ IADLs, or health-related services.

   Example B: Person has mild cerebral palsy but needs no help with anything.

3. A person could have ADL/IADL deficits, but not eligible for Family Care—if s/he is not in a Family Care target group.

   Example: 34 year old man with schizophrenia needs prompting with numerous ADLs/IADLs, but does not have a physical disability or any other target group condition. (See discussion of mental illnesses below.)

How to Answer the Target Group Question

A person can be in more than one target group. Check all that apply.

The target group question does rely on the professional judgment of the screener applying the **statutory definitions** of these terms. The statutory definitions are on page 16 of the LTC FS.

The statutory definitions are somewhat vague and open to interpretation. The definitions overlap with but cannot be reduced to objective data of diagnoses or ADL/IADL needs. Fortunately, county human service staff have been using these definitions for years in current waiver programs. Consult with your Resource Center peers and managers often. A nurse should be available to assist screeners with questions. For the developmental disability (DD) determinations, if you have all the necessary information (such as I.Q. score and diagnoses), consult with staff of the Bureau of Developmental Disability Services. If you do not have such information, refer as discussed below.

Refer to MD or Psychologist If Necessary

In some instances, physicians or psychologists will need to be consulted (for example, to determine whether person meets federal definition of developmentally disabled). Resource Centers may occasionally need to help the person get an MD appointment to obtain diagnoses and determine

whether person is in one of the target groups. County CSPs (Community Support Programs) have psychologists and psychiatrists who can determine whether an individual meets definitions for developmental disabilities.

Data entered elsewhere in the functional screen should correlate with the target group question. For example, if you checked "Alzheimer's or other irreversible dementia" here, there should be a dementia diagnosis checked in the diagnoses table.

Target Group Definitions

Each of the statutory definitions is reproduced in bold below, with interpretive guidelines for each.

"Infirmities of aging" means organic brain damage caused by advanced age or other physical degeneration in connection therewith to the extent that the person so afflicted is substantially impaired in his or her ability to adequately provide for his or her care or custody" (WI Statutes 55. 01(3)).

Interpretation: This definition is grammatically ambiguous. Read it in the following way:

Organic brain damage caused by advanced age, or
Other physical degeneration in connection with advanced age,
Either of which substantially impairs the person's ability to adequately provide for his or her care or custody.

"Organic brain damage" is not restricted to the specific diagnosis of organic brain syndrome. Here, "organic" is an adjective to distinguish the brain damage from, say, traumatic head injury. "Advanced age" here is interpreted as age 65 or older.

"Dementia" means Alzheimer's' disease and other related irreversible dementias involving a degenerative disease of the central nervous system characterized especially by premature senile mental deterioration and also includes any other irreversible deterioration of intellectual faculties with concomitant emotional disturbance resulting from organic brain disorder (WI Statues 46.87(1)(a)).

"Organic brain disorder" here is not limited to the specific diagnosis "organic brain syndrome." "Irreversible" is something you can not always tell by diagnosis alone. For instance, alcoholic dementia or drug-induced dementia may or may not be irreversible. You need to consult a health care provider to specifically ask whether the dementia diagnosed is irreversible or not.

It is sometimes impossible to distinguish "organic" brain disorders from "mental illness" or from alcohol or other drug abuse. In fact, the separation makes little sense clinically. You certainly can't tell by looking, and you can't tell by history: A person could have had mental illness but now be manifesting dementia. You need to get some help from a health care professional. If the consumer does not have a health care provider to contact for diagnoses and other information, you'll need to facilitate getting the consumer an appointment for an evaluation.

"Physical disability" means a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, which results from injury, disease or congenital disorder and which significantly interferes with or significantly limits at least one major life activity of a person" (WI Statutes 15.197(4)(a) 2).

> **"Major life activity" means any of the following: A. Self-care. B. Performance of manual tasks unrelated to gainful employment. C. Walking, D. Receptive and expressive language, E. Breathing, F. Working, G. Participating in educational programs, H. Mobility, other than walking, I. Capacity for independent living." (WI Statutes 15.197(4)(a)1).**

The major life activities here overlap with ADLs and IADLs on the screen, but not precisely enough to have the screen data replace this definition.

Note that checking this target group question refers to this statutory definition. It does NOT require a social security determination of disability. (SS disability determination is needed for waiver eligibility in 2000, but not for Family Care eligibility.)

Physical Disability or Infirmities of Aging?

In truth, most "infirmities of aging" are physical disabilities, so in many instances both definitions might apply. (A good example is arthritis, which in an old person is considered age-related, but in a young person is considered a physical disability.) For eligibility purposes, you can check either one or both target groups. To be precise, however,

- Check only "Infirmities of aging" if the condition developed late in the person's life, i.e., is related to age.
- Check only "Physical disability" if the person had a physical disability at a young age and now just happens to be age 65 or older.

  Example: A healthy 66 year old person with paraplegia from an accident at age 43.
- Check both "Infirmities of aging" and "Physical disability" if both apply to separate conditions.

  Example: A 66 year old person with paraplegia from an accident at age 43 who also has congestive heart failure and rheumatoid arthritis.

Dementia or Infirmities of Aging?

Dementia is listed as a separate target group in order to capture people younger than age 65 with dementia. If the person is 65 or older, both target groups can apply.

- Check only "Dementia" if the person does not have any other conditions that meet the definition of "Infirmities of aging."
- Check both if the person does have other conditions that meet the definition of "Infirmities of aging."

Dementia or Mental Illness?

You can't tell by looking, and you can't tell by history: A person could have had mental illness but now be manifesting dementia. You need to get some help from a health care professional. If the consumer does not have a health care provider to contact for diagnoses and other information, you'll need to facilitate getting the consumer an appointment for an evaluation.

FEDERAL DEFINITION OF DEVELOPMENTAL DISABILITY: A person is considered to have mental retardation if he or she has – (I) A level of retardation described in the American Association on Mental Retardation's Manual on Classification in Mental Retardation, or (ii) A related condition as defined by 42 CFR 425.1009 which states, "Person with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:

- **(a) It is attributable to—**
  - **(1) Cerebral palsy or epilepsy or**
  - **(2) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.**
- **(b) It is manifested before the person reaches age 22**
- **(c) It is likely to continue indefinitely**
- **(d) It results in substantial functional limitations in three or more of the following areas of major life activity: Self-care; Understanding and use of language; learning; mobility; self-direction; or capacity for independent living.**

Note that the consumer must meet the federal definition of DD in order to be eligible for certain waivers, i.e., to get a "DD level of care."

County records and school records are often helpful, in addition to or instead of health care records. A written diagnosis of mental retardation or developmental disability suffices. Families or guardians often retain copies of such documentation. For the developmental disability (DD) determinations, if you have all the necessary information (such as I.Q. score and diagnoses), consult with staff of the Bureau of Developmental Disability Services. If you do not have such information, refer to an MD or psychologist for an evaluation as discussed above.

STATE DEFINITION OF DEVELOPMENTAL DISABILITY: "'Developmental disability' means a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome, mental retardation, or another neurological condition closely related to mental retardation or requiring treatment similar to that required for mental retardation, which has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual. 'Developmental disability' does not include senility which is primarily caused by the process of aging or the infirmities of aging" (WI Statutes 51.01(5)(a)).

Wisconsin's definition of DD is broader than the federal definition, in that it does not include the restrictive clauses "b" (onset before age 22) and "d" (substantial functional limitations) of the federal definition. In order to be eligible for the home and community based waivers for DD persons, the consumer must meet the federal definition of DD. Persons meeting only the state definition but not the federal definition are not waiver eligible. They may still be Family Care eligible.

For the developmental disability (DD) determinations, if you have all the necessary information (such as I.Q. score and diagnoses), consult with staff of the Bureau of Developmental Disability Services. If you do not have such information, refer to an MD or psychologist for an evaluation as discussed above.

Brain Injury
In Family Care, traumatic brain injury will be included with the "Physical Disability" target group (even if the resulting symptoms are only cognitive or behavioral).

A person with brain injury may meet the federal definition of DD if the injury occurred before age 22. If the brain injury occurred after the age of 22, the person may meet the state definition of DD but not the federal definition. Screeners can check either or both of those target groups (PD plus either federal or state DD) for persons with traumatic brain injury. Brain injury will be evident through the diagnoses table of the LTC FS. *(In 2000, the current methods for eligibility determination for brain injury waiver will continue. The LTC FS and its logics may be adjusted if needed to do such determinations later in 2000.)*

Mental Illness and Substance Abuse ("Co-Morbidity")

"Co-morbidity" means having more than one diagnosis; in this document it refers to having a mental illness and/or SA along with physical disability, infirmity of aging or developmental disability. Estimates are that from **40 to 70%** of long term care recipients also have mental illness and/or alcohol or drug abuse (AODA) issues. In practice, it is sometimes impossible to distinguish mental illness and AODA-related conditions from "infirmities of aging" or "dementia." (The separation here is because the redesign of Wisconsin's mental health system is on a separate track from Family Care, and is hoped to be temporary.) We know that this causes difficulties for Resource Center staff and screeners. To reduce confusion, please follow these steps:

First, ask whether person meets **statutory definitions** for at least one Family Care target group. To do so, you must focus **only** on the physical, medical, or cognitive condition you are considering (ignoring their mental illness) and ask whether it satisfies a statutory definition.

> **If YES:** Check "yes" to all target groups that apply, and continue with the screen. The person may **also** have mental health or SA issues; as noted above, many LTC consumers do. They are eligible for Family Care if they are in at least one target group and if they have functional limitations—i.e., they need help with ADLs/IADLs.
>
> Note that this method does NOT ask what the PRIMARY diagnosis is, and it does not ask the reason for the ADL/IADL limitations. So, someone whose "primary" diagnosis is mental illness could in fact be eligible for Family Care—as long as s/he ALSO has PD, DD, infirmity of aging, dementia, or terminal condition, and ADL/ IADL deficits. CMOs are required by contract to provide or contract for Mental Health/ AODA services, including Community Support Program services.
>
> **If NO:** If person is known to have ONLY mental health and/or SA issues, none of the Family Care target groups can be checked because person does NOT have DD, PD, infirmity of aging, or terminal condition in addition to mental illness or SA. Stop there—this person is INELIGIBLE for Family Care. The Resource Center should refer the person to other programs, especially mental health, but also Medicaid fee-for-service for help with ADLs/ IADLs.
>
> This is an example of how it's possible for a person to have ADL/ IADL deficits WITHOUT being in one of the Family Care target groups (i.e., without having PD, DD, infirmity of aging, or terminal condition). Mental health providers are responsible for helping people whose ADL/IADL needs result only from mental health problems.

Second, continue with the screen to see if person is functionally eligible, i.e., has ADL/IADL deficits specified in Family Care eligibility criteria. (Again, the screen does not ask the reason for the ADL/IADL deficits.)

> *Example: 67 year old man with residual schizophrenia also has advanced COPD (chronic obstructive pulmonary disease) and CHF (congestive heart failure) that make him very short of breath and weak. It is clear that the COPD and CHF significantly impair his ability to function. (Or would if he ever tried to do his ADLs/IADLs; providers tend to just do them for him because of his schizophrenia.) Check "Infirmities of Aging."*

Mental Illness Co-Morbidity and Medications

As noted in previous section, many people in Family Care target groups will also have mental illness and AODA diagnoses. It does not matter which diagnosis is "primary." It does not matter which problem causes ADL/IADL limitations. All that matters is that the consumer with mental illness or AODA diagnosis also meets one of the Family Care target group definitions.

The statutory definitions allow for consideration of the special instance when a person due to mental illness cannot self-manage a physical disability or infirmity of aging.

If the person is unable to self-manage medications or treatments for a medical condition, then the condition counts as an infirmity of aging or a physical disability if the failure to take the medications is **life-threatening**. Examples include insulin for diabetes, or medications for high blood pressure (to prevent strokes) or medications to prevent blood clots.

The logic involves using a counterfactual: If the person didn't have a medical condition requiring life-sustaining medications, she could probably live on her own despite her mental illness (even if not well, e.g., homeless). But because she has diabetes or high blood pressure requiring medications, and because her failure to take the meds would be life-threatening, she cannot live on her own. Therefore, the medical condition does "severely impair her capacity for independent living" or self-care. So the medical/physical condition does meet statutory definition of physical disability or infirmity of aging, so she is in a Family Care target group.

If the medications are not life-sustaining –i.e., if failure to take the meds is not life-threatening—then the medical condition does not "severely impair her capacity for independent living." Unless it otherwise severely impairs functioning, then it does not meet statutory definition of physical disability or infirmities of aging.

The inability to take only psychotropic medications does not apply here, because there is no separate physical disability or infirmity of aging causing the need for those medications. The mental health system would need to help the person take medications.

Examples: Consider three different women, all in their late 60's, all with long histories of mental illness variously diagnosed as schizophrenia, bipolar disorder, personality disorder, and psychoses with periods of paranoia and delusions. Each woman is unable to take medications on her own due to her mental illness.

> *a. Mary is only on psychotropic medications and has no physical or medical conditions that significantly impair her ability to function:*
>
> > *Mary is not eligible for Family Care because she does not meet any of the target group statutory definitions. Mental health providers must find ways to help her take her psychotropic meds.*

b. Stella is on several psychotropic medications. She also has arthritis—it is mild, and does not significantly impair her functioning enough to qualify as a physical disability or infirmity of aging. Stella is given Tylenol or Ibuprofen for the arthritis pain.

Stella is not eligible for Family Care because her physical condition (arthritis) does not significantly impair her functioning, and her inability to manage her arthritis medicine is not life threatening, i.e., does not significantly impair her capacity for independent living.

c. Sophia is on several psychotropic medications. She is also on insulin for diabetes and pills for high blood pressure and congestive heart failure. The diabetes and high blood pressure do not significantly impair her functioning in themselves. However, Sophia's failure to take these medicines would be life-threatening, so these conditions do "impair her capacity for independent living" or self-care. So, she does meet statutory definition for physical disability or infirmities of aging, so she does meet a Family Care target group definition.

This approach may mean that some persons currently being served by mental health clinics – specifically, those who come in daily for meds that include insulin, blood pressure meds, etc—would meet the target group question. Those persons may be functionally ineligible for Family Care if they do not have sufficient number of ADL/IADL deficits; or they may be functionally eligible at the Intermediate or Comprehensive level.

Note that this approach to Family Care eligibility is not the same as eligibility in the current waivers. No Social Security disability determination is needed. Again, you must have a separate medical or physical condition (or dementia) to consider separately from the mental illness and you must ask whether that condition impairs the person's functioning significantly enough to meet the statutory definition for a target group.

What If No Target Group Applies?

Explain to the consumer that s/he does not appear to meet any of the statutory definitions for a Family Care target group, and so is not eligible for Family Care. Since the LTC FS is completed after conversations between the screener and consumer, it is expected to be rare that you would even try to do a screen for someone not in a target group. If a consumer disagrees with the screener about their target group status, the screener should consult with a supervisor and/or refer to a physician or psychologist for an opinion. The screener will also provide counseling and referrals for the consumer's other service options.

For now, the LTC FS computer program considers a screen "incomplete" if no target group is selected. Such screens will not be allowed in to the EDS database for storage. The RC can store paper copies if desired.

Later, when the LTC FS is actually determining eligibility, the consumer (or representative) will have the right to appeal the eligibility determination.

Age

To be eligible for Family Care, a person must be 17 years 9 months old or older. If the date of birth entered indicates that the person is younger than this, a pop-up window will appear to ask if this is correct and if you still want to continue. The screen can still be done, to allow for advance planning.

Instructions for Page 1 of LTC FS

Resource Center
Enter name or abbreviation of county Resource Center.

Referral Date
Enter the date that someone contacted the Resource Center to request that a screen be done.

Leave this field **blank** if no one referred the person for a screen. This applies only during the transition period when LTC FS will be done as part of enrolling current waiver clients into a CMO.
The field is mandatory if Screen Type (page 2 of LTC FS) is "Pre-Admission."

See Resource Center contract for details on timelines expected between date of referral and date of completion of LTC FS.

Date of Birth
Enter the person's date of birth in MM/DD/YYYY, as in 01/01/1909.

Page 2 of LTC FS– Screen Details and Consumer Address

Demographic information will not determine eligibility for LTC services. It will be used for two purposes:
(1) as part of the foundation for a CMO's full assessment (if the person chooses a CMO)
(2) for state and county data for quality assurance and program oversight.

Wherever you see "Other" and a line, check the box and write in a description. PRINT LEGIBLY.

Screen Type

Check **ONLY ONE box**.

Option 04 "Pre-Admission screen" refers to a screen done as part of Pre-Admission Counseling (PAC). PAC is required for all persons entering nursing homes (which include ICF-MRs and FDDs), community-based residential facilities (CBRFs), adult family homes, and residential care apartment complexes (RCAC), also known as assisted living facilities.

PAC is also required for people newly applying for a home and community based waiver, so that is included here (4e) --even though it's not an admission to a facility.

If both PAC to a facility (4 a-d) and application to waiver (4e) apply, select the applicable PAC (4 a- d) option.

Referral Source

Indicate who contacted the Resource Center to refer this person for a screen. Check only one box.

If no referral was made (e.g., you are screening current caseload during transition period), check box 14 "Other" and write in "rollover." Otherwise Referral Source is a mandatory field.

Primary Source for Screen Information:

Select only one box.
"Primary" means the majority, over 50 %.
In some instances the information is obtained almost equally from multiple sources; please select the one that seems most accurate.

In the majority of cases, screeners will need to have collateral contacts with family, residential staff, health care providers. In most cases, the primary source for screen information can still be the consumer.

If the consumer uses an interpreter, the consumer -- not the interpreter-- is still the primary source of information.

This question is meant as a quality assurance reminder that screeners must not take shortcuts and complete a screen from talking with caregivers, staff, etc., if the applicant could participate in the screen. If the person is not the primary source of information, it is expected that in most cases other parts of the screen will indicate significant cognitive limitations. It will also be used in research to explore differences in LTC FS depending on who provides information.

Where Screen Interview Was Conducted

Person's current residence includes private homes, residential facilities, or nursing homes.

Nursing homes include ICF-MRs and FDDs. Select this if the nursing home is not the consumer's current residence. If the nursing home is the consumer's current residence, select box 01 instead. We know that this question is not always easy to answer and rely on screeners' experience and expertise to select the most accurate answer.

"Temporary residence (non-institutional)" is intended for instances when consumer is staying with family or friends temporarily, for instance to recuperate from an illness or surgery. It also includes temporary stays in residential facilities, such as respite in a CBRF. Do not check this is person is in an institution such as hospital or nursing home.

If you did more than one in-person interview with the applicant in two different settings, you may check both.

If you check "Other" please write a description such as Resource Center or county office.

Applicant's Address
"Applicant" is the consumer you are screening as part of application to Family Care or home and community based waivers.
Include street number, street name, apartment number, city, and zip. Include telephone number if available. For transient person, enter the address they lived at the most in the last 6 months.
If the person is now in a facility, that may or may not be their "permanent residence."

County of Residence and County of Responsibility
In most cases these will be the same. In a few instances, the person lives in one county but another county is responsible for services, costs, and/or protective services.

Page 3 of LTC FS -- Demographics continued

Medical insurance

Check ALL that apply. Write in the person's Medicare number, and check box to indicate Part A or B or C as applicable. Note: Part C is a new form of voluntary HMO Medicare called "Medicare Plus Choice." You may see it written as "M + C."
Private insurance includes employer-sponsored insurances (e.g., an HMO) available as a job benefit. You do not have to write in the names of private insurance or private long term care insurance.
"Other" includes Veterans' Administration, railroad insurance, etc.

Race/Ethnicity

Please select only one box. The choices here match federal insurance reporting requirements.

An Interpreter Is Required. If so, in what language?

Leave this box unchecked if no interpreter is needed.

Check it and indicate the language if an interpreter is needed. If "Other,' please write the language in. Human service and health care providers should always obtain interpreters when they are needed. This information will help show the extent of such needs, and will also help the CMO if the person chooses to enroll in Family Care.

Guardian of Person

Leave box unchecked if person does not have a guardian of person.

Only guardian of person and activated power of attorney for health care (POAHC) were deemed important for the LTC FS.

Representative payees, unactivated power of attorneys, and other detailed functionaries were not considered necessary for this screen. The CMO will cover those details in their comprehensive assessment.

A "comment" section has been added to the LTC FS and its database to allow screener to write in any important details if desired. For instance, if there is a shared guardianship, you can write in the second guardian's name and address in this field.

Check the box if appropriate and provide the guardian's name, phone number, and full address. This information may be needed to complete the screen, and/or to notify the guardian of the consumer's eligibility determination.

Activated Power of Attorney for Health Care

Leave box blank if person does not have an activated power of attorney (POAHC) for health care. Only guardian of person and activated power of attorney for health care were deemed important for the LTC FS.

Representative payees, unactivated power of attorneys, and other detailed functionaries were not considered necessary for this screen. The CMO will cover those details in their comprehensive assessment.

Check the box if appropriate and provide the activated POAHC's name, phone number, and full address. The Resource Center and the CMO might need to contact the activated POAHC if any medical emergencies arise.

Page 4 of LTC FS - - Residence Questions

Current Usual Residence

Check ONLY ONE box to indicate the person's current usual place of residence.

Most of the categories are self-explanatory.

9—Residential Care Apartment Complex (RCAC) is what is commonly (or formally) known as "assisted living."
12—Community Based Residential Facility (CBRF) includes "group home. "
18—Other IMD = Other institute for mental disease not captured in 17.
19 – Child Caring Institution is included to allow for screens done before person's 18th birthday.
21—Other: Please write in what the "Other" is, for possible screen revisions in future.

For instances in which more than one category seems applicable, please follow these guidelines:

- If consumer lives with family and family is being paid as an adult family home, choose box 2, lives with spouse/partner/family (instead of box 7).
- If consumer lives with family/spouse/partner who is being paid to provide services such as personal care, choose box 2, lives with spouse/partner/family (instead of box 4).
- If person lives with non-related roommates (box 3) **and** has live-in paid caregivers (box 4), select box **4**.

1. Where would this person <u>like</u> to live?
Select only one box.

This is the only question on the LTC FS that asks precisely and only for <u>the consumer's own stated preference</u>. It will be used to see if CMO members are living where they want to live and to track changes over time.

This question is asking the PERSON'S INFORMED PREFERENCE. Record where s/he would like to live—not where anyone else wants them to live, and not where you or others think is realistic. Screeners must take the time to <u>explain the person's options</u> as part of LTC options counseling and Pre-Admission Counseling (both detailed in Resource Center contract). The consumer cannot express a preference if the screener has not informed them of their options first.

It is well known that people often acquiesce to whatever they feel limited to or whatever they've been told. For example, people with developmental disabilities who live in institutions often think "group home" is the only option available to them. You must take the time to ask questions to help the person articulate her/his preferences. Some people like to live with others; others highly value having

their own space. While the person's preference may be difficult to ascertain, screeners are to use their best interviewing skills to select the most accurate answer.

As another example, an old woman may say she "belongs in" a nursing home because she'd be too much of a bother anywhere else. The screener should take the time to ask what she would like, not what she thinks is reasonable.

Screeners should select the answer that most accurately reflects what the person is saying. An elder may articulate a preference for "an apartment with onsite services (RCAC, independent apartment CBRF)." But if a person with developmental disability is telling you that she just wants "a place of my own," then you check box 02- "Wants to move to own home/apartment." You do NOT check box 03, "apartment with on-site services," even if that's probably what the person would get. The purpose of this question is to record what the person says, not what the system will provide or what you think s/he really needs.

Box 6, "Wants to move but unsure where": The "where" here refers not to the exact address to which to move; rather, it refers to the type of living situation. Check this box only if your discussion of options does not yield a close answer from any of the other choices 1 through 5.

Check box 7 "Unsure, or unable to determine" if the person cannot comprehend their options and/or cannot communicate their preference.

> *Example: John is a 34 year old man with developmental disability who lives in a group home. The screener takes the time, using simple questions, to learn that John doesn't really like his roommate or the group home on the outskirts of town. The screener takes several minutes to talk to John to learn that he would really like to live alone, in an apartment where he could have his own space and his own cat. Screener checks box 2 to indicate that John seems to be saying that he would like to move to his own home or apartment.*
>
> *In actuality, the screener judges that John would probably need on-site services, so the screener considers other choices more accurate. But this question—unlike most of the rest of the LTC FS—is asking precisely and only for John's preference. John did not state anything close to the other choices. (He did not say, "I want to move to a group home." He said he wants his own apartment and that he wants to live alone. This question is only asking his preference. If John was helped to move, it might be to an RCAC or independent apartment CBRF, he might like it and his LTC FS next year might show his preference as box 1, "Stay at current residence." But right now what he is saying is most accurately reflected in box 2, "Move to own home or apartment."*

2. What is the guardian's/family's preference for living arrangement for this individual?
This question was added because screeners found the previous question too difficult to answer when the guardian or family disagreed with the consumer being screened.

Select only one box.

Pages 5, 6, and 7 of LTC FS - Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

ADLs = activities of daily living: bathing, dressing, eating, mobility, transfers, and toileting.

IADLs = instrumental activities of daily living: meal preparation, management of medications & treatments, money management, use of telephone, transportation, and employment. (Employment is not usually considered an IADL, but is on the LTC FS.) On the LTC FS, chores and laundry are included in the IADL section but do not "count" as IADL deficits in the current eligibility logic.

Each ADL and IADL has its definition provided. Follow those definitions closely.

One rating system has been developed for all of the ADLs. The IADLs require separate rankings because their respective descriptions are so different.

In all cases, the ranking has been simplified to meet the following criteria:

- As simple as possible for maximum uniformity (inter-rater reliability)
  Imperative for accurate and equitable determination of eligibility and entitlement
- Inclusive:
  A screener is able to select one "most accurate" answer without lying, for every individual of any of the Family Care target populations
- Make sense for eligibility: Some things should not "count" toward eligibility for a LTC program.
  Example: John lost his license for DWI. His inability to drive should not count as an IADL deficit in eligibility for LTC programs.
- Relate to LTC costs
  See discussion below

Level of Help and LTC Costs

In general, the rankings for "level of help needed" correlate with costs for LTC services. In ADLs, box 1 indicates that helper does not have to be present throughout the task. This level is generally less expensive than level 2, in which helper does have to be present throughout the task—at least in congregate settings. Level 1 captures the common scenario in CBRFs where one helper can handle several residents, each of whom may only need reminders, cues, set-up, or brief help with only parts of each ADL.. Level 1 might take only 2 minutes to get someone started with a shower or bath, while Level 2 might take 15 or 20 minutes to actually be there throughout the task. Note that Level 2 includes all cases in which the helper has to be present throughout the task: It does not ask whether the helper is doing the task completely, helping partially, or just providing verbal cueing and supervision for every part of the task. Since the labor costs are generally the same, these descriptive differences were ignored to make a more simplified LTC FS. Also, it is understood that Level 1 (e.g., helping someone in and out of a bathtub) usually costs the same as Level 2 if the helper is making a visit to the consumer's home.

In the IADLs, the rankings correlate with frequencies of interventions needed (monthly, weekly, daily, etc.) which in turn generally correlate with LTC costs.

The Risk module and the substance abuse and mental health questions do not follow this pattern of ranking correlating to costs. They are instead more descriptive.

Not all LTC costs are captured on the LTC FS, in order to keep the screen as brief as possible. In managed care, some things can be allowed to average out among the LTC populations. Further statistical analyses will be done to make the LTC FS a succinct but accurate predictor of consumers' LTC needs and costs.

DETAILS OF LEVEL OF HELP NEEDED TO COMPLETE ADLs SAFELY:

0	**Person is independent in completing the activity safely.**
1	**Help is needed to complete task safely but <u>helper DOES NOT have to be physically present throughout the task.</u>** **"Help" can be supervision, cueing, or hands-on assistance.**
2	**Help is needed to complete task safely and <u>helper DOES need to be present throughout task.</u>** **Help can be supervision, cueing, and/or hands-on assistance (partial or complete).**

Choosing Level of Help Ratings for ADLs

Each ADL has its own definition purposefully constructed for the purposes of the LTC FS. Screeners are to follow the definitions precisely in order to select the most accurate rating for level of help needed.

Always select the answer that most closely describes the person's need for help from another person- - whether they're actually getting that help or not. More specific instructions are found in discussions of each ADL and IADL listed below.

Check ONLY ONE box for the level of help needed with each ADL and IADL.

Discharge Imminent: If the person is now in a hospital or nursing home, and will go home in the next few days, record the help they'd need **at home**. Talk to the discharge planner, family, person, PT, OT, etc., to get the most accurate possible picture.

Example A. The facility, for liability reasons, may help everyone with bathing, but the person may or may not be expected to need help with this task at home.

Example B. The person may be independent transferring out of an electric hospital bed, but will probably need help transferring out of bed at home.

Example C. The person is independent in toileting in the hospital. She'll be going home in two days with a commode, and is expected to be independent using that.

Adaptive Equipment

Some of the ADLs have some adaptive equipment listed. Check any equipment that the person currently has. Do NOT check off any that the person seems to need but does not have yet. Not all adaptive aids are included on the LTC FS. Their omission is intentional. This is a compromise between the current Wisconsin COP eligibility (in which use of any adaptive aids "counts" toward eligibility) and the previous approach that if a person independently performs a given ADL with

adaptive aid, that ADL does not "count" toward eligibility. The compromise in the LTC FS is that only significant durable medical equipment count toward eligibility. So, for example, wheelchairs and walkers count but canes do not count toward eligibility.

Example: Margaret is 83 years old and has arthritis and congestive heart failure. She uses a walker. She is slow but steady and does not need any help with ambulation from another person. Margaret is marked "0" for level of help needed, and the box for walker is checked. Mobility counts as an ADL for Margaret because of the walker.

A person's untried potential for using assistive devices should not be considered. Note that the person may need help due to physical limitations, cognitive impairments, or both.

For each ADL & IADL, indicate the amount of **help the person currently needs from another person**—no matter who is providing the help, and no matter where. The only exception to this is that when a person is about to move very soon, estimate what they'll need in their new setting. See section on "Discharge Imminent" above.

CODING FOR WHO WILL HELP IN NEXT 8 WEEKS

For each ADL and most of the IADLs there are codings to indicate for who will help in the next 8 weeks:

CODING FOR WHO WILL HELP IN NEXT 8 WEEKS: Check all that apply.

U	Current UNPAID caregiver will continue.
PP	Current PRIVATELY PAID caregiver will continue.
PF	Current PUBLICLY FUNDED paid caregiver will continue.
N	Need to find new or additional caregiver(s).

This is for information only. It does not affect the consumer's eligibility for LTC programs.
The level of informal or private pay help will NOT affect a person's level of payment in the new system. (It will all average out, between persons with a lot of informal help and persons with none.)
The information will be used for two purposes:

- To inform the CMO that the consumer may need services immediately or soon. The 8 week period is rather arbitrary; it's to warn the CMO when they have less than 2 months to find additional helpers for the consumer.
- For DHFS research. This information is needed to understand low costs for persons with high needs, so that adequate average payments can be established.

If the level of help needed for a particular ADL/IADL is "0" (or "NA"), the column for "Who will help in next 8 weeks" should be left blank.

The screener must speak with the consumer and her/his caregivers to know whether the current supports can last for 8 weeks and beyond. See examples below.

Do not check "N – Need to find new or additional caregiver(s)" if all that's needed is **occasional respite**. The "Risk Module" has additional questions about respite and caregivers. (See examples there.)

Publicly Funded includes Medicare, Medicaid, waiver funds, and any other federal, state, or county funds.

"PP--Privately paid" means non-public funds—including the person's own money, or that of family, friend, etc., or private insurance, or a trust fund. (If it is the person's out-of-pocket expenses, it will count as medical/remedial expenses in financial eligibility determinations.)
Private pay here includes co-pays if they're paid for a particular service. Medicare and Medicaid home health and personal care services do not have co-pays, so those are just "PF—Public funded."

Example: Mildred has just moved into an RCAC (Residential Care Apartment Complex) after a lengthy hospitalization. She is now receiving some Medicare-covered home health nurse and home health aide visits. Medicare is expected to cover only 7 more weeks of these visits, but Mildred will need help with bathing for long term. Mildred can do her own bath, she just needs help getting in and out of the tub. Mildred is independent in her other ADLs.

- *For Bathing, the screener checks Level 1 for help needed (helper does not have to be present throughout the task).*
- *For Bathing, screener checks "PF" to indicate publicly funded "(Medicare) services **and** "N – Need to find new or additional caregiver(s)."*

For each of Mildred's other ADLs and IADLs, the screener checks "0" for level of help needed, and leaves the "Who will help in next 8 weeks" column blank.

PARTICULAR ADLs

Bathing – Definition as per LTC FS.

Examples of Level of Help Needed = 1: (Helper does not need to be present throughout task"):

- *Elderly person only needs help getting in and out of the bathtub, but is safe sitting in tub alone and can bathe self. Helper is present at beginning and end, but does not have to be present throughout the task.*
- *DD person needs someone to tell him to shower, gather towel, etc., and to turn on the water so he won't scald himself. He is then safe alone in the shower, so helper can leave.*

Examples of Level of Help Needed = 2: (Helper does need to be present throughout task"):

- *Elderly person takes a shower and is not safe standing in shower alone due to risk of falling, and/or cannot wash self.*
- *DD person needs someone present throughout the shower to talk him through every single step or to provide hands-on assistance.*

Rank the person on **how they would prefer to bathe**. If they are giving themselves a "sponge" bath because they are unable to get in and out of tub or shower, rank the level of help they need in order to take a tub or shower. If they actually prefer to sponge bathe (and can do so independently), rank them as "0," independent with bathing.

It is not uncommon for consumers to under-rate their need for help with bathing. Remember to use the three steps described earlier (on page 3, concerning inaccurate self-descriptions from consumer):

1. Seek more details.
2. Seek collateral informants, other people you could ask for additional information.
3. Use your professional judgement to select what seems to be the most accurate answers. follows the definitions and instructions for the screen.

Example: Bert tells you he doesn't need any help with bathing. He lives alone. He is unkempt and smelly. He walks very unsteadily with a cane, is bent over, and is unable to lift either leg off the floor when you ask him to. It's quite clear to you that he is not able to safely get into and out of his bathtub and that he in fact has not bathed for many weeks.

Step 1: Seek more details.

You ask him if you can see his bathroom, where you notice that he has a claw-foot bathtub with sides about 2 feet high off the floor (with no grab bars, bench, or non-slip mats).

You observe his ambulation and ask him to lift his foot high for you.

You ask him for details on how he gets in and out of the bathtub.

Step 2: Seek collateral informants.

Bert's daughter referred him to the Resource Center and is present during the screen interview. You speak to her privately on the way out to get her perspective on her dad's functioning. She says he's lying now because he's afraid, but he's admitted to her that he is unable to get into the bathtub.

Step 3: Use your professional judgement to select the best answer.

You can see from Bert's general body movement that he would need help with all aspects of bathing, not just getting in and out of the tub. For bathing you select box 2, "Helper needs to be present throughout the task."

The fact that someone is receiving a bath at an adult day care center does not automatically mean they should be ranked a "2" for level of help needed. Screener should ask for details and observe consumer's general mobility, steadiness, report of safety, reports of dizziness, ability to reach feet and over head, etc. It may be that a level of help "1" is more accurate than "2."

If person does not currently have adaptive aids or safety equipment such as grab bars or tub bench, indicate the level of help they need from another person now, without such equipment.

If the facility routinely installs grab bars or other equipment, rank the person on whether or not s/he actually uses the equipment. Remember, you're trying to describe the person's functioning, not the services they receive.

Dressing includes dressing top half of body, dressing bottom half (e.g., putting on undies and pants), getting shoes and socks on and off, and applying prostheses, braces, or "TED" stockings. If the person only needs help with one of those, select Level 1, because helper does not have to be present throughout the entire task of dressing.

IADLs – Instrumental Activities of Daily Living

Each IADL has its own definition that screeners should follow closely.

Check ONLY ONE box for the level of help needed with each IADL.

For each IADL, indicate the amount of **help the person currently needs from another person**—no matter who is providing the help, and no matter where. The only exception to this is that when a person is about to move very soon, estimate what they'll need in their new setting. See section on "Discharge Imminent" above.

Note that the definitions are of **"the ability to"** perform the IADLs. If a competent person with full decisional capacity[1] makes the informed choice to mishandle her finances or eat junk food, they may nonetheless be marked "0- Independent" with IADLs. A competent person choosing to gamble or to spend all his money on cigarettes and junk food are commonly-cited examples of such people. You should not indicate that they need help from another person with meal prep or money management unless they are unable to manage them.

Employment
Part B. If Employed, where:

Option 1 – "Pre-vocational day activity/work activity program" refers generally to programs for people residing in institutions such as ICF-MRs or the state centers.

Page 9 of LTC FS -- DIAGNOSES

Diagnoses

Medical information is often not readily available when a screen is being done in a community setting. Screeners must **verify the** diagnoses and health-related services. Medical information is "verified" if it is:

1. Stated to screener by an MD, RN, or other health care professional, or
2. Copied from recent health care records, or
3. **Very clearly** stated –in exact words--by the person, family, advocate, etc.
   Exceptions to this criterion are psychiatric diagnoses, behavioral diagnoses, and dementia. People commonly say that someone has "Alzheimer's" or "depression" without a confirmed diagnosis. So screeners must confirm those diagnoses with a health care provider or medical record.

Screeners will need to contact the person's doctor's office and ask for medical diagnoses and health related services. At the same time the screener should verify health-related services and target group information.

Diagnoses Table

The diagnoses table is not meant to be inclusive. Only some of the more common diagnoses are here. This table does include almost all of the diagnoses on the MDS (Minimum Data Set) which nursing homes must complete. It is permissible to refer to the MDS, or any other health care providers' documentation, to complete this module, but screener must confirm that the information is still **current. "Current" is defined as no more than one year ago and still applicable.** Screeners should check with health care providers to confirm that the medical information is still applicable.

For diagnoses, **check ALL that apply.** For convenience, the diagnoses are grouped by major categories (e.g., Pulmonary, Cardiovascular, Neurological). Screeners should use the "Diagnoses Cue Sheet" provided by DHFS in order to know which box to check for a given diagnosis not listed on this table.

[1] "Decisional capacity" is a broader concept than legal competence. A person (whether legally competent or not) has decisional capacity to make a particular decision if she can understand the pros and cons and decide in a way that reflects her individual values (not necessarily professionals' values).

Do not try to interpret the consumer's complaints or symptoms. Do not take psychiatric or dementia diagnoses at face value; they must be confirmed by health care provider.

Example A: Family says elderly father is "really losing it," and "He's getting Alzheimer's." Screener asks family if a doctor has made this diagnosis. Family said no, father hasn't been to a doctor for awhile, but "It's gotta be, he forgets so much now." Screener does NOT mark "Alzheimer's." Screener gets permission to call MD's office, and asks nurse to call back to provide diagnoses.

Example B: 82 year old Betty has diabetes and is complaining of increasingly poor vision. Screener does NOT check "I 1. Cataracts/ Glaucoma/Diabetic Retinopathy" based on this alone.

Example C: 79 year old Ida has swollen ankles and gets short of breath with exertion. She says she's on a "water pill," and has a "bad heart, you know." Screener does not guess Congestive Heart Failure (although it's likely), but contacts Ida's home health nurse for diagnoses.

Example D: David is a 32 year old man diagnosed with moderate mental retardation who has occasional outbursts of violent behaviors whenever something happens that upsets him. Screener does not guess "impulse control disorder" or any other behavioral or psychiatric label. Screener only includes diagnoses provided by health care providers (or DD experts). (Behavioral symptoms will be described in other modules of LTC FS.)

Page 10 of LTC FS - - Health-Related Services

Health-Related Services

To be eligible for federal home and community based waivers, a person must be eligible for a nursing facility (also known as meeting nursing home level of care). This table is extremely important in determining a person's waiver eligibility and Family Care eligibility (Comprehensive or Intermediate). The table and a complex computer program were developed with experts from the Bureau of Quality Assurance (BQA) who set nursing home levels of care, and experts from the Bureau of Developmental Disabilities Services (BDDS) who set DD levels of care. Instead of having to mail information to a BQA or BDDS expert for level of care determinations, the computer can provide it to the screener upon completion of the LTC FS.

Screeners are not expected to be medical or nursing experts. **In almost all cases, screeners must consult with a health care provider in order to accurately complete the Health Related Services table.**

HEALTH-RELATED SERVICES NEEDED	**PERSON IS INDEPEN-DENT**	***FREQUENCY OF HELP/SERVICES NEEDED FROM OTHER PERSONS***				
		Weekly or less often	2 to 6 days/ week	1 to 2 times a day	3 to 4 times a day	Over 4 times a day

This table requires only check-marks by the screener, to show the presence of and frequency of each health-related service. Leave spaces blank if not applicable.

First, read down the list of medical conditions or tasks in the far left column. You will place one checkmark in the row of any condition or task that the person has. If the person is completely independent in doing the tasks and managing the condition, place a checkmark in the column to show that "Person is Independent." (This shows that the person has that condition, which will be valuable information for the CMO and for DHFS research.)

If the person is not independent in managing a condition, you place one checkmark in the column showing the most accurate frequency of "Help Needed by Another Person."

If the person is independent with a task or condition, you just check that column; there is no indication of the frequency at which the person does the tasks. The frequencies are only shown for "help/services needed from other persons."

If the person needs help from another person, you need to place a checkmark in the column that most accurately reflects the frequency of help needed. It does not matter who is performing the task: In general, this table is looking for "skilled nursing tasks," but in community settings, families are often taught to do even very technical skilled nursing tasks. The definitions for each condition (each row) will list the "skilled" tasks that you are to focus on, and in some cases tell you which tasks to ignore. For instance, in the rows for urinary catheter, you are to ignore the unskilled tasks like emptying the bag, and only consider the skilled tasks (replacing the catheter, irrigating it).

In many cases, the person is independent in some tasks, but needs help from another person in addition. Pay attention to the column heading that shows that the frequencies are "Frequency of help/services needed from **other persons**."

Example: Inez does her own ankle dressing (for a Stage 3 stasis ulcer) twice a day. But Inez can't see well and can't judge if it's getting worse or better. A nurse examines it once a week to be sure it's healing well and to adjust the wound care as needed. Inez calls the nurse if she has any problems in between. You mark "Weekly or less often" for the "frequency of help/services needed from other persons." Be careful not to mark the twice a day task that Inez does independently under the heading for help from other persons.

You can also mark "Person is independent" [with twice daily dressing changes] in addition to the mark for the "Weekly or less" help needed from another person. Or you can leave it blank.

If you check more than one frequency column, the computer system will count only the higher frequency. Alternatively, screeners can choose the higher frequency task and put only one checkmark to indicate that.

For conditions that are continually present (e.g., an indwelling catheter), your checkmark should indicate the frequency of tasks related to the condition. When one condition involves more than one task, you can check both, or just check the most frequent task.

Example A: *Bob has an indwelling urinary (foley) catheter in continually. The catheter is changed (by a nurse) every 60 days. Daily "cath care" is just soap and water as normal part of bathing and is not really considered a "health related service" on this table. No irrigations are needed. Bob has a tracheostomy. Tasks related to this include changing the trach tube once every month, and cleaning the trach site ("trach site care") twice a day. He is generally self-directing and stable and visits his doctor's office only once every 4 to 6 months.*

Screener places TWO checkmarks:
Urinary catheter-related skilled tasks at "Weekly or less often" and
Tracheostomy Care at "1 to 2 times a day".

Instructions for Particular Health-Related Services:

The left-side column contains a mix of conditions and interventions, and so need a mix of interpretations to make the best use (the most clinical sense) of this table. Please refer to the guidelines below for each particular row.

"Interventions" in this table includes monitoring and having someone present to prevent a behavior, as well as more direct interventions such as redirecting the person, physically preventing the behavior, and responding to problems caused by the behavior.

INTERVENTIONS related to BEHAVIORS

Currently in Wisconsin this affects nursing home and DD level of care determinations. Other sections of the LTC FS should correlate with this row; i.e., "Offensive or Violent Behaviors" or "Self-Abusive Behaviors" should also indicate interventions.

"Behaviors" refers to acts that require interventions by others to prevent or respond to the behaviors. It does not include passivity or acts of omission such as self-neglect.

CONDITION - REQUIRES NURSING ASSESSMENT or skilled medical monitoring by persons trained and overseen by nurse… Condition may be unstable or deteriorating (e.g., infections, gangrene, dehydration, malnutrition, terminal condition, exacerbation, AIDS, etc.), and/or result from multiple health risks in person unable to manage them or to communicate problems.

Screeners will need to consult with a nurse or physician to be able to answer this question accurately. Even if screener knows of a condition (such as malnutrition), to know the frequency of nursing or skilled monitoring, the screener will need to consult with health care providers. The clause for "skilled medical monitoring by persons trained and overseen by a nurse" is meant to include family members who are so trained to care for persons in the community. In institutional settings, there would be a nurse available.

Do not over-use this row. In particular, do not check it if other rows already include all the nursing assessment or skilled medical monitoring that the person needs. For example, if you checked a frequency of interventions for pain management, and the person has no other "skilled nursing" needs, then do not check this row for "Condition" as well.

IV CHEMOTHERAPY

"Chemotherapy" means anti-cancer medicines administered via intravenous (IV). Chemotherapy has its own row because its administration is highly skilled and it has significant side effects. Other IV medicines (such as antibiotics) are listed in "IV Medications" row.

Chemotherapy is often administered once a day for 3 to 5 days in a row, once a month, for several months. Unless it is to be stopped soon, select the frequency (usually " 1 to 2 times a day") for the days it is given. Other nursing monitoring for cancer care can be captured above in the row for "Condition requires nursing assessment…" if appropriate.

EXERCISES/RANGE OF MOTION

This task actually does not play a role in BQA determinations of nursing home level of care, but is included in this table because it is commonly encountered in community long term care. This row captures exercise programs and "range of motion" exercises that are done by the person themselves or anyone else including family or staff. The exercises may or may not have been set up by a physical therapist, occupational therapist, or speech therapist (PT, OT, ST), and the helpers may or may not have been trained by PT, OT, ST, or RN. If the exercises are being performed by a PT, OT, or ST, you would instead check the row at the bottom of the table to indicate the frequency of such skilled therapies.

IV FLUIDS

This is intravenous fluids (usually "normal saline," or weak solutions of "dextrose," not to be confused with TPN described below) administered to provide adequate hydration (fluid status) in person unable to drink enough water. Usually only temporary, for acute dehydration or until tube feedings can be established. This does NOT include "TPN" which has a separate row.
Mark the frequency of interventions needed, not just administration of fluids. For instance, starting an infusion in the PM and disconnecting it in the AM = two tasks.

IV MEDICATIONS (DRIPS OR BOLUSES not chemotherapy)

Anti-cancer medicines, called "chemotherapy," have separate row above.

This row captures other medicines administered through an IV (intravenous) line. Most common are small bags (1 to 2 cups of liquid) of antibiotics that "drip" in (usually via an IV pump for safety). Sometimes a medicine is squirted directly in instead (this is called "bolus" and is a very skilled, i.e., potentially dangerous, task).

In most cases, IV medicines drip in over 30 or 60 minutes, which is essentially one visit by a nurse; this can be called one intervention even though it combines several tasks (starting the med, flushing and disconnecting afterwards).

Mark the frequency of interventions needed, not the frequency of med administration.

Example A: Many times a computerized IV pump delivers a med three times a day, but the IV only needs to be set up (refilled and re-programmed) every two or three days. In between set-ups, the IV works fine and the consumer/family know how to handle problems and when to contact the nurse. You'd check the "2 to 6 days a week" column for the set-up every 2 to 3 days. (Other rows such as "Condition requires nursing assessment…" can be checked if that is needed in addition.)

Example B: Person has "PCA" – "Patient-Controlled Analgesia," which is a special IV pump that the person can trigger to deliver tiny doses of pain medicine many times an hour, throughout the day and night. You would mark the frequency that they need the pump re-filled and reset, or otherwise need help from another person.

MEDICATION ADMINISTRATION (not IV); OR ASSISTANCE with pre-selected or set-up meds.

This row is about "Taking" medications—by any route except intravenous (IV). If person can take medications independently, check the "Person is Independent" column. If person needs someone to give them their medications, there are three general possibilities:

1. **Med Administration:** This is a skilled task in which the nurse or someone trained by a nurse administers the meds; administration includes selecting the proper med and dosage and being able to judge whether a medicine should be taken or withheld due to symptoms or side effects.

2. **Assistance with Pre-Selected Meds:** An unskilled person (without the judgement about giving or holding a med) can "assist" with medications that have been "pre-selected" - - that is, the proper med and dosage have been selected in advance by a pharmacist, a nurse, or someone trained by a nurse. This "pre-selecting" is called "medication set-up." "Medication set up" is defined and indicated in the "Medication Management" row below.

3. **Assistance with Self-Medication:** This is when a self-directing consumer has the cognitive ability to select the proper med and dosage and the judgement to understand the medications' purpose and side effects and to report problems, but needs someone to physically assist with the medicine. This includes, e.g., the person with quadriplegia who instructs a personal assistant to help him with his meds under his close direction.

MEDICATION MANAGEMENT – SET-UP &/or MONITORING (for effects, side effects, adjustments) -- AND/OR BLOOD LEVELS

Check to indicate the frequency at which someone needs to do any of the following:

1. **Medication set-up**: Includes:
   - bubble-packs from a pharmacy
   - "pill boxes" or "med boxes" with compartments labeled for different times and each day of the week, into which a nurse or other trained person places the pills that are to be taken at those times on those days;
   - any other "set up" system in which meds and dosages are pre-selected.
   - medication dispensing machines that can be programmed (often weekly) to dispense pills.
   - Pre-filling of syringes (most commonly insulin syringes)
2. **Medication Monitoring**: This is skilled monitoring for the effects and side-effects of medicines. It includes reporting such information to the prescribing physician or nurse practitioner and making changes as prescribed by them.
3. **Blood levels:** Includes drawing blood samples (through access port or phlebotomy) for laboratory tests. The majority of these are related to medications (e.g., Pro-Times to regulate Coumadin administration, or potassium levels for person on diuretics). Other blood draws not strictly related to medications can be included here as well.

   Blood levels also includes include "finger-sticks" for capillary blood to test blood sugar levels.

OSTOMY–RELATED <u>SKILLED</u> SERVICES

"Skilled" tasks include changing the wafer (which adheres to the skin and needs to be cut to proper size to avoid skin breakdown around the ostomy), doing site care (skin care around the ostomy, where

the wafer will attach), and irrigations. Wafer changes and site care is usually done only once every 7 to 10 days for a stable ostomy, but much more frequently for a new ostomy or one with problems like leaking and skin breakdown.

Do not include the unskilled task of emptying the ostomy bag.

OXYGEN

Oxygen is often worn continually; screeners should find the frequency at which the person needs help from others with particular tasks related to the oxygen. If the person is independent in turning the oxygen on and off, putting it on and off, and changing water bottles and tubing, then check the column for "Person is Independent." Do not include the oxygen vendor's trips (usually every few weeks) to provide new tanks.

PAIN MANAGEMENT

This is to be considered separate from medication management. Pain management is specifically doing a complete pain assessment and providing pain coping mechanisms in addition to medications.

Just administering or assisting with routine medicines for stable chronic pain can be captured in the rows for "Medication administration or assistance."

If you check this row for pain management, do not also check the row for "Condition requires nursing assessment" unless there are other problems in addition to the pain.

Even with significant chronic pain, a person may self-manage it and not need pain assessments and management by someone else.

POSITIONING IN BED OR CHAIR every 2-3 hours

This was added by request of screeners as a descriptive item, although it currently does not play a part in BQA RN's determinations of level of care. If person can reposition independently, you can just ignore this row.

RESPIRATORY THERAPY: NEBULIZERS, IPPB TREATMENTS, BI-PAP, C-PAP; (does NOT include inhalers)

Check the number of times ON AVERAGE that the person needs these breathing treatments. IPPB treatments & nebulizers involve pouring a precise amount of liquid medicine into an aerosolizing machine.

Do NOT include hand-held inhalers or aerosols, which have pre-metered doses. (If person needs help with those, just include it the medication assistance row above).

Use this row to record frequency for other respiratory treatments such as "C-PAP" or "Bi-PAP" and chest physiotherapy and postural drainage.

IN-HOME DIALYSIS

This is sometimes done by the person/ family themselves, or might involve a nurse coming in. Count hooking up and disconnecting as two separate tasks. So, if a person has overnight peritoneal (through the abdomen) dialysis, that counts as two tasks (hooking up and disconnecting) at a minimum.

Dialysis done in a dialysis clinic is not included on the table, because the dialysis clinic is responsible for the person's health, and nurses there see the person usually three times a week. Only if the person is very unstable at home (or has other problems) would you also check the "Condition requires skilled nursing assessment…"

TPN (TOTAL PARENTERAL NUTRITION)

This is when the person gets all their nutrition through an IV (intravenous) line. Because the solution is extremely high in sugars, there is high risk of infection and of dangerously abnormal blood sugars. So TPN is always run via an IV pump for precisely controlled infusion rate.

If it runs continually, the frequency of help needed may be 3 to 4 times a day to hang new bottles (or bags).

TRANSFUSIONS

IV (intravenous) infusion of blood products. Rarely done on an on-going basis more than weekly.

TRACHEOSTOMY CARE

Includes changing trach ties, cleaning site, changing trach tube, suctioning. Since there are multiple tasks included, screener should check the frequency of the most frequently done task. For example, the trach tube is changed once a month, site care is done twice a day, and suctioning is done on average 3 to 4 times a day. Screener puts checkmark in the 3 to 4 times a day column.

TUBE FEEDINGS

NG= nasogastric = A feeding tube down the nose (or mouth) and esophagus to the stomach.

(Rare and temporary, due to risk of aspiration into lungs and discomfort in nose and throat.)

G-tube = gastrostomy = tube goes through the abdomen into the stomach.

J-tube = jejunostomy = tube goes through the abdomen into the intestine just below the stomach.

"Mickey" = a special button apparatus to hold the G-tube in place.

If the person is on continuous tube feeding, the tasks (checking for placement, starting a new bag of feeding, etc.) are most often done "3 to 4 times a day." You do not need to separate out every single task if several are done at the same time. Instead, indicate the general number of times a day that the tube feeding is changed, started, stopped, etc. Do not include flushing the tubing after med administration. So, if the person can eat and the G-tube is being used only for meds, the only task might be changing the G-tube every 30 days or so.

ULCER –STAGE 2

This is only the very beginning of skin breakdown, a very shallow red area. Check this row only if special skin care is being done; do not check it only for band-aids or routine skin care.

ULCER—STAGE 3 OR 4

These are "pressure sores" caused by lying or sitting on the site, that go all the way through the skin. They're usually "bedsores," but can also result from prolonged sitting in a wheelchair.

Sores on ankles and feet -- usually called "stasis ulcers" –can be included here as well.

Check the frequency at which interventions are needed as column headings indicate.

Example: Inez does her own ankle dressing twice a day. A nurse examines it once a week to be sure it's healing and well, and to adjust the wound care as needed. Inez calls the nurse if she has any problems in between. You mark "Person is independent" [with twice daily dressing changes] and you mark "Weekly or less often" for the "frequency of help/services needed from other persons." Be careful not to mark the twice a day task that Inez does independently under the heading for help from other persons.

URINARY CATHETER-RELATED SKILLED TASKS (irrigation, straight caths)

"Straight caths" or "Intermittent urinary catheterizations" are an "in & out" cathing, done usually every 4 to 8 hours. If person self-caths, indicate the frequency they do them.

An indwelling catheter stays in most or all of the time, or perhaps overnight. If overnight, putting it in and taking it out count as 2 separate tasks.

Skilled tasks include changing (replacing) the catheter, and irrigating the catheter (done for infections and if catheter tends to get clogged with sediment). Do NOT count routine "cath care" as a task here—it's usually just soap & water as normal part of bathing. Do include "site care" if it's a suprapubic catheter (one which goes in through a small hole in the skin just above the pubic bone).

OTHER WOUND CARES (NOT CATH SITES, OSTOMY SITES, OR IVs)

Do NOT check wound care if you already checked for pressure ulcer (because wound care is implied there.) Check this box only if the person has other wounds.

"Wound care" means, at a minimum, changing dressings. Do NOT include band-aids. Wound care might also include cleaning, irrigating, and/or packing a wound. Some new gel dressings can be left on for 7 to 14 days at a time. These include Una boots, algiderm, duoderm, etc.

If a person has more than one treatment, or more than one wound, put one checkmark to show the most frequent task.

VENTILATOR–RELATED INTERVENTIONS

This means a mechanical volume ventilator. Do NOT check this for "C-PAP" or "Bi-PAP"; include those in the "Respiratory Therapy" row above. Some people can self-manage their ventilator. Others require very frequent oversight and interventions round the clock.

OTHER: write in:

Do NOT write in a diagnosis unless you have confirmed that it is not on the "Diagnosis Cue Sheet" provided to screeners.

SKILLED THERAPIES – PT, OT, ST *(Any one or a combination, at any location)*

Check here only if person is currently getting therapies **by a licensed therapist**, to show the frequency of PT, OT, or ST. This does NOT include exercises done by a person alone or by other caregivers, even if under the instructions of a therapist.

Page 11 of LTC FS - - Communication & Cognition

The screener must have a face-to-face contact with the person-- in addition to the use of a record review and collateral contacts if necessary-- to complete this module. Medical records including mental status exams may be referred to, if done within the past year, and if still current. Ask health care providers familiar with the person whether such documents are still accurate.

If the person has serious deficits in cognition and is living alone in the community without significant support, Resource Center staff are expected to follow up to assure the person's health and safety. Such follow up could include an immediate referral to a CMO for urgent services, assistance getting fee-for-service services, or referral to Adult Protective Services or any other prevention/safety programs available.

The categories of Memory and Cognition for Daily Decision-Making do overlap, but the combination helps to clarify needs for diverse populations of LTC consumers.
Follow the definitions closely.

Resistive to Care
This means physically resistive due to cognitive deficit. This question was added because it is an eligibility criterion developed by a LTC Redesign workgroup. It is meant to indicate people who are **physically resistive** to cares due to a cognitive impairment. There must be an element of cognitive impairment. There does not have to be a legal declaration of incompetence, but there should be some medical diagnosis, or other parts of the screen, indicating cognitive impairment.

Page 12 of LTC FS - - Behaviors/ Mental Health

This module relies on **both a history and a structured interview process** to accurately record a participant's behavior that may have an effect on the cost of the individual's long term care services.

"Interventions" in this module includes monitoring and having someone present to prevent a behavior, as well as more direct interventions such as redirecting the person, physically preventing the behavior, and responding to problems caused by the behavior.

Wandering: A resident of a facility may not be able to "elope" due to alarms, etc., at the doors. You would still indicate how much s/he "wanders" within the facility.

Self-Injurious Behaviors: Follow the definition on the screen. This is not to be interpreted more broadly: That is, it does not include all behaviors that may have unhealthy consequences, such as smoking, or promiscuity, or eating sugar despite diabetes.
Select the answer that most accurately reflects the frequency of interventions needed for this behavior.

Mental Health and Substance Abuse Questions

It is estimated that from 40 to 70 % of long term care consumers also have mental health and/or substance abuse issues.

It is recognized that many people will not divulge this information during the screening process. However, the information is important to share with the CMO, and for rate-setting and quality

assurance. Screeners should ask about mental health and substance abuse diagnoses when confirming other diagnoses, health-related services, and target group questions.
Screeners should also use their professional interviewing skills to elicit the most accurate possible answers to these questions. Questions from nationally standardized screens such as the "CAGE" questionnaire and other screens for geriatric populations could be used to elicit information to help screeners answer the LTC FS questions.

Page 13 of LTC FS -- Risk Module

The Risk Module has been redesigned to do the following:

- Identify consumers at Intermediate level who have confirmed need of APS services.
- Identify consumers who may be nursing home eligible due to imminent risk of institutionalization.
- Identify consumers with other risk factors that CMO should be warned.
- Allow screener to record statements or evidence of abuse found during screening process.

Newly discovered cases of abuse and/or neglect should result in a referral to APS for investigation, case planning and any necessary court related services. This module does not replace the function and process of the APS unit.

RISK MODULE PART A: CURRENT APS OR EAN CLIENT

Persons found eligible for Family Care at the Comprehensive level are eligible and entitled to the Family Care benefit. "Entitled" means they cannot be put on waiting lists, and their chosen CMO cannot refuse to enroll them. Persons found eligible for Family Care at the Intermediate level are eligible but not entitled, unless they:

- Have a Medicaid card, or
- Are on the county's "grandfathering" list, or
- "Has a confirmed need for Adult Protective Services (APS) services."

Only APS staff are qualified to determine whether a consumer "has a confirmed need of APS services." A referral to APS does not constitute a confirmed need for APS services.

A1: Person is known to be a current client of APS.
This reads "is known to be…" in recognition of the fact that the screener may not know the person is a current APS client, and the consumer being screened may not divulge this information to the screener. You should ask as part of screening.

A2: Person is currently being served by the lead Elder Abuse and Neglect (EAN) agency.

EAN is separate from APS, and an EAN client may or may not "Have a confirmed need for APS services." The screener will ask if the person is a current APS or EAN client. If the person is an EAN client, the screener may contact the local APS unit to determine whether this EAN client "has a confirmed need for APS services." Note: You do not have to do this if the consumer appears eligible at the Comprehensive level; the "confirmed need for APS services" only matters if the person is eligible at the Intermediate level. When this is the case, you should inform the APS unit of this, so they'll get back to you with their determination as soon as possible. (Meanwhile, you can refer the person for financial eligibility processing, etc.)

RISK MODULE PART B – RISK EVIDENT DURING SCREENING PROCESS:

Check **any** that apply.
Note that whether the consumer is aware of and chooses a level of risk is irrelevant here. They may well choose to take the risk. But the screener is here indicating that, in her/his professional judgment, there is some risk. The screener then follows up in accord with her/his usual professional judgement.

0. No risk factors or evidence of abuse or neglect apparent at this time
At least one box in Part B must be checked. Check "0" if no other fields apply, i.e., if there is no risk evident to screener.

1. The individual is currently failing or is at high risk of failing to obtain nutrition, self-care, or safety adequate to avoid significant negative health outcomes.

2. The person is at imminent risk of institutionalization if s/he does not receive needed assistance.

Option 1 and 2 will be described together because they overlap. Box 1 is Wisconsin APS language and is essentially informational only. It plays no role in eligibility determination.

Box 2 is federal language specifically intended for persons who will be deemed nursing home eligible because they are "at imminent risk of institutionalization if they do not receive the needed assistance." The federal Health Care Financing Administration (HCFA) advised states that "imminent risk of institutionalization" means that the person "would require nursing facility care within 6 to 8 weeks if [community-based] services were not provided."[2]

Box 2 is **critical** in determining the consumer's nursing home eligibility. (Persons not deemed nursing home eligible from the Health-Related Services table—i.e., those who don't have sufficient "skilled nursing" needs—may be deemed nursing home eligible if the screener checks this box in the Risk Module. Screeners should consider this box carefully and check it if it applies.

Box 2 could be checked for a person with quadriplegia, no matter who is providing him help. For instance, the family could be doing the cares. Perhaps he is stable and not on medications and has no skilled nursing tasks; he would, however, be "at imminent risk of institutionalization" in a nursing facility if he did not receive help with his ADLs and IADLs

Box 1 is broader than Box 2, and can include persons for whom Box 2 does not apply. In other words, the person may be at risk, but you may have no indication that they'd be admitted to a nursing facility within 6 to 8 weeks if they didn't get help.

> *Example: Helen is a 90 year old woman living alone, independent in all ADLs & IADLs, with no obvious cognitive impairment, no behavioral problems or other symptoms. Yet she is living in a tiny rundown house with 32 cats, filthy conditions, and broken plumbing. She says she eats three meals a day, doesn't mind the cat hair, cat urine and feces, etc., throughout the house, and doesn't need any help. She has no medical conditions and no health-related services at all. Screener box 1 to indicate that Helen is "currently failing or at high risk of failing to obtain." But screener would not check box 2 because it is not clear that Helen would be eligible for nursing home (let alone at risk of nursing home placement) within 6 to 8 weeks.*

[2] O'Keefe, Janet. Determining the Need for Long-Term Care Services: An Analysis of Health and Functional Eligibility Criteria in Medicaid Home and Community Based Waiver Programs. The Public Policy Institute of the American Association of Retired Persons. 1996. p. 5.

3. There are <u>statements of or evidence of</u> possible abuse, neglect, self-neglect, or financial exploitation

If yes: □ Referring to APS and/or EAN now

□ Not referring at this time, because competent adult refuses to allow referral

Comments:

Screener can check this box to provide warning to the CMO that the person is possibly at risk.

In many instances, the screener would report the case to APS or EAN. However, reporting is left to the professional judgement of the screener, because (1) competent adults can refuse to allow such referrals, and (2) sometimes making the referral would only exacerbate the situation. In the latter case, the screener could ask for advice from APS staff without divulging consumer info, and continue to interact with the person as part of Resource Center general responsibilities.

Use the comment field here to write in the details of what you have heard or observed concerning the risk.

4. *The person's support network appears to be <u>adequate at this time</u>, but <u>may be</u> fragile in the near future (within next 4 months)*

This box too is only informational for the CMO.

SCREENER FOR ALL PRECEDING FUNCTIONAL MODULES, AND TIME TO COMPLETE THIS PART OF SCREEN:

The "Functional Modules" are Modules I through VI, all except the Financial Module.

Screener: It is expected that ONE person complete all of the functional modules. In some cases, a different person (perhaps an income maintenance worker) may do the financial module, so that two people may do one screen. No more than two screeners should be involved in one screen.

Date: Indicate the date that this part (Modules I through VI) was completed. It may take more than one day to complete these modules, especially if screener must wait for information from health care providers.

Time to Complete This Part of Screen: This section is important to establish proper reimbursement to Resource Centers for performing screens. Fill out the four times here; the computer application can sum them up for the total. Write the time in as **hours and minutes rounded to the nearest 15 minutes.**

GRANDFATHERING QUESTION

Check with your supervisor to see how your county is handling the process for grandfathering people.

Basically, each county with a CMO has compiled a list of persons who meet the department's grandfathering criteria. Those on the grandfathering list can be eligible for Family Care even if they "fail" the LTC FS, or can be entitled to Family Care even if they're only eligible at the Intermediate level. (Which is generally a determination of eligibility but not entitlement, meaning that they could be put on waiting lists.)

Pages 14 & 15 of LTC FS - - Financial Module

A new, shorter "financial declarations page" will be developed in June/July 2000. For now, this is the same financial module that has been on the functional screen since 1998, with the numbers updated to year 2000 figures. This financial module is voluntary.

General Guidelines about gathering financial information:

Development of financial information (i.e., questioning and probing) should be kept to the minimum needed to secure information with a reasonable degree of accuracy. It should not be so intrusive as to deter people from participating in what is a voluntary exercise. The extent of questioning should be decided on a case-by-case basis within these general parameters.

Where an average monthly figure is required, use a 12 month period beginning with the application (screening) month to compute the average. Use current information to project future figures except where there is reasonable evidence to forecast changes in financial circumstances over the next 12 months.

Pre-Screen Income Estimate:

This table is a "short-cut" to get an approximation of the person's income. It can be checked off for everyone (except SSI cash beneficiaries), but it is especially for people who refuse to do the rest of the financial screen. Many "private-pay" people will not want to answer all the other detailed financial information in this module. Tell them that it would be helpful for the DHFS to know general income of persons entering the LTC system, so that we can do budget estimates that include cost-sharing by those able to contribute. (You might want to tell them that we often find when we review people's income and expenses that their likely share of service costs changes (or improves) so we hope they will answer all the financial questions.)

Financial screeners have found people are more willing to point to a pre-printed financial range than to state their income. You might hand them a General Income card (one side for singles and the other for couples/families) and ask if they would point to the category that best describes their income. (As always, adjust your method to the individual's needs.)

PART 1

A. SSI/MA Status
Line 1a. - Check **Yes** if person is currently receiving an SSI or SSI state supplement payment. Also check **Yes** if a person is eligible for SSI but not getting an SSI payment this month due to a calendar related income fluctuation (e.g., an extra paycheck month, receipt of a quarterly, semi-annual or annual payment), but will get one next month. Since persons receiving SSI will have no cost share, enter 0 on Line 29.

Line 1b. - Check **Yes** if the person is currently eligible for MA but not for SSI. Since persons eligible for MA will have no countable assets for cost sharing, enter 0 on Line 9 and go to Part 1. C.

B. Eligibility based on 12 Month Estimate of Assets of Participant.
General Guidelines - Count the assets of **both the applicant and a spouse, if any**, unless specifically instructed to count only those owned by the applicant. Application of spousal impoverishment asset protection (Line 4) will allocate a share of the assets back to the spouse. Unless specified differently here, follow MA rules in determining and valuing countable assets. See the MA Eligibility Handbook and/or the 2000 COP Cost-Sharing Worksheets and Instructions for assistance or consult with a county Economic Support Specialist.

Line 2- Add cash on hand plus current amounts in all savings, checking, money market, certificates of deposit, individual retirement accounts, Keough accounts, money in a nursing home resident's personal account, CBRF prepayments and any other liquid financial accounts. If the account has a penalty for early withdrawal, use the estimated value after deducting any penalty. Total all financial accounts.

Count the principal of a trust fund only if the trust was established with the applicant's own assets (or that share so established) and MA rules do not exempt the principle as a countable asset. See an Economic Support worker to determine this. Do not count a trust established by a third party if that party is not legally responsible for supporting the person.

For joint accounts, consider the entire value of the account available to the applicant **unless** the joint owners are MA recipients **or** both spouses are applying, in which cases the account is apportioned equally, **or** the applicant states that someone else deposited the funds in the account and actually owns them.

Determine the current value of all stocks, bonds, mutual funds, mortgages, notes, commodities such as precious metals and other securities or financial instruments owned. Total. Estimate if necessary.

Determine the cash surrender value of any life insurance which the applicant owns. Subtract any loans against the cash value. Ignore all term insurance because it has no cash value.

Total the value of all cash, bank accounts, securities and cash value of life insurance. Enter on Line 2.

Line 3 - Other Countable Property

The following is non-countable (excluded) property:

1. The home, including all related outbuildings and contiguous land. This is exempt as long as the applicant, applicant's spouse, child under 21, disabled child or other dependent resides in it. For an applicant in out of home placement, the home is exempt for up to one year from when the applicant left if the applicant intends to return, unless one of the other above persons resides in it or other circumstances warrant extension. A life estate in a home is also exempt.
2. Household goods and personal possessions.
3. One car if used to provide necessary transportation.
4. Income Producing Property - Property used in a trade, business or profession and real property which generates income are excluded if in current use. This includes a farming operation, rental property and other business property. Current use means that the property is now being used in the activity designed to generate income, or if not in use for reasons beyond the applicant's control, has been so used in the past and there is a reasonable expectation that such use will resume within 12 months of last use. This may be extended for another 12 months if non-use is due to the applicant's impairment(s). In addition, to be excluded, the property must be generating estimated net income in the current tax year, or if not, there is a reasonable expectation that the property will generate net income in the following tax year. However, property in a business in operation for less than three years shall be excluded if there is a reasonable basis for concluding the business will be profitable in the third year, such as movement toward profitability. In addition, to be excluded, rental property must produce a reasonable amount of income, considering its value and marketability. Follow the instructions in the MA Eligibility Handbook for determining whether there is net income from farming, business or rental property or consult an Economic Support Specialist for assistance.
5. Savings/Checking Account Composed of Work Earnings - A separate account composed entirely of earnings from work is an excluded resource as is the interest earned by the account. **This applies only to funds accumulated in such an account after the person begins receiving long term care services through Family Care.** It does not apply to savings from income earned prior to the beginning of Family Care.
6. Funds received within the last 12 months to replace lost, damaged or stolen excluded resources listed above or otherwise excluded (e.g., insurance payments).
7. Funds received as loans unless available to pay for long term care services

The following is other countable property:

1. Non-Homestead Real Property, i.e., real estate other than primary residence-Count the equity value of such property if it is not excluded rental or business property. The equity value is the estimated fair market value minus what is owed. If there is more than one owner, apportion equal shares to each owner and count only the value of the applicant's share. But do **not** count if:
    a) the property is listed for sale with a realtor at a fair market price or other reasonable efforts to sell are being made; or

b) is jointly owned with a person not responsible for the applicant's support who refuses to sell; or
c) is jointly owned with someone whose sole residence it is, who refuses to sell and who would lose the home if sale were forced.

2. Funeral and Burial Assets-Count amounts paid for a burial space for the applicant, including plots, caskets, vaults, crypts, mausoleums, urns, niches, etc., as well as for headstones or other markers and arrangements for opening and closing the gravesite. Also count amounts in an irrevocable burial trust or separately identifiable burial fund for the applicant.
3. Additional Vehicles- Count the equity value of additional cars or other vehicles owned by the applicant or spouse unless excluded as business property.
4. Other Property-Count at equity value if countable under MA rules. See the MA Eligibility Handbook or consult an Economic Support Specialist.

Enter total estimated value of countable other property.

Line 4 - This line totals countable assets.

Line 5 - This line allocates a share of the couple's assets to the non-applicant spouse using MA spousal impoverishment protection rules. The spouse may not be receiving COP or MA Waiver services or be in a nursing home for more than 30 days.

Line 6 - This line subtracts out the spouse's asset share.

Lines 7 - 8 - Persons residing in a nursing home, ICF-MR, CBRF, or adult family home are considered residing in an out-of-home placement. Other persons are in their own residence.

Line 9 - Multiplication by .0833 on Line 9 is to determine one twelfth of countable assets to be added to income each month.

C. Income of Person Applying for LTC Service Funding
General guidelines: Use only the income of the person applying. If income is received in both spouses' names, count one half. If income is received in the names of the applicant and another person(s), count the applicant's proportional share. Use current income unless you anticipate based on concrete evidence that changes will occur over the next 12 months, in which case the changed amount(s) should be incorporated in deriving average monthly income.

Line 10 - Enter your best estimate of average monthly income from earnings--wages and/or self-employment--after subtracting estimated monthly federal and state income and FICA (Social Security and Medicare) taxes. For employed persons a pay stub is a useful source of information but a declaration is sufficient for now. Tax returns are useful for more accurately determining after-tax income but are not necessary at this time. If the applicant reports rental income to the IRS as self-employment income it may be counted here; otherwise count it on Line 13. Do not count earned income tax credit payments.

Line 11 - This line calculates the earned income disregard. From the amount on Line 10 subtract $200. Multiply the result by .67. Add the product to $200 and subtract the result on Line 11 from Line 10. Enter if less than or equal to $1250; if greater than $1250, enter $1250.

Line 12 - This line subtracts the disregard from after-tax earned income.

Line 13 - Enter a best estimate of average monthly **gross money income from all other sources for the next 12 months.** Include only the applicant's income. This includes but is not limited to:

1. Social Security/Railroad Retirement (**do not** add back in the Part B Medicare premium);
2. Pensions and annuities;
3. Interest and dividends;
4. Capital gains;
5. Veterans' pensions or cash assistance;
6. Means-tested public assistance in cash (SSI, TANF, General Relief, RNIP);
7. Child support and spousal maintenance (alimony);
8. Unemployment and worker's compensation;
9. Income from trusts or estates;

10. Net rental income (Unless counted as self-employment income on Line 10. Calculate by talking total rental income and subtracting the mortgage payment and verifiable operational costs. If the applicant resides in one of the units, follow the procedure in the MA Eligibility Handbook for calculating net rent.);
11. Royalties;
12. Educational grants for living expenses;
13. Payments received from land contracts and other installment sales; and
14. Any other unearned income countable by MA. Consult MA Eligibility Handbook or an ES worker if necessary.

Do not count:

1. foster care payments received as a provider ;
2. payments received to purchase a social service (e.g., supportive home care, respite, day care,);
3. unearned in-kind income or benefits;
4. income tax refunds;
5. homestead tax credit payments;
6. loans that must be repaid;
7. funds received to replace lost, stolen or damaged excluded resources (e.g., insurance payments on a house, apartment furnishings or car);
8. payment of bills by a third party;
9. adoption subsidies received from the DHFS;
10. unless otherwise stated, any type of income not counted by MA (see MA Eligibility Handbook or ES worker);

Line 14 - This line totals countable earned and other income.

PART 2: PARTICIPANT SHARE

Lines 15-16 - Self explanatory

Line 17 - Enter unearned income of dependent children **excluding** both any means-tested benefits (e.g., SSI, TANF, Caretaker Supplement) and social security benefits the child receives. Exclude any earnings of dependent children.

A dependent child is the applicant's natural, adoptive or stepchild who receives at least 1/2 of his or her support from the applicant, unless the applicant is divorced and claims the child as a dependent under the divorce decree. If the child is over age 18 (or 23 if a student), the child can have no more than $2650 of his or her own income to be counted as a dependent.

Line 18 - This line adds together countable monthly income and assets to determine monthly resources.

Line 19 - If there is a non-applicant spouse who is neither receiving COP nor MA Waiver services nor in a nursing home for more than 30 days, this line determines the maximum amount of income the applicant could allocate to the non-applicant spouse to increase the latter's income up to the amount specified in spousal impoverishment protection rules. Enter the amount of income needed to bring the spouse's gross monthly income up to the **lesser** of $2,103 or $1,843.33 plus an excess shelter allowance. Calculate this as follows:

1. Determine the spouse's shelter costs. These are the sum of the spouse's costs for rent or mortgage, property taxes, insurance, required condominium or cooperative maintenance fees, and a standard utility allowance of $201 if the spouse pays heat & all utilities, $115 if pays utilities but not heat, or $27 if pays just telephone. Assume the spouse will pay all such costs including those now paid from the applicant's income.
2. Determine the excess shelter allowance, if any. If total shelter cost is less than or equal to $553 per month, there is no excess shelter allowance; otherwise, subtract $553 from shelter costs. The difference, up to $259.67, is the excess shelter allowance. If greater than $259.67, the allowance is $259.67.
3. Determine the maximum income allocation, that is, the amount of the applicant's income that could be allocated to the spouse if the spouse had no income of his or her own. If there is no excess shelter allowance, the maximum is $1843.33. If there is an excess shelter allowance, add it to $1843.33; the result is the maximum income allocation (no greater than $2103).
4. Determine the spouse's total gross monthly income (earned and unearned) with no deductions. If Medicare eligible, be sure to include the Part B premium deducted from the Social Security payment.

5. Subtract the spouse's monthly income from the maximum income allocation. The result is the spousal income allowance. Enter on this line. If negative or 0, enter 0.

Note: Whether the spouse can actually receive this much depends upon whether the applicant has this much available to allocate.

Line 20 - This line determines the allowance for dependent children as defined in Line 17 instructions and other dependents (who must be claimed as dependents for tax purposes) residing with the applicant, or if the applicant is in out of home placement, with the applicant's spouse. Multiply the number of dependents--children and any other--who **reside full time** with the applicant (or spouse if applicant is in out of home placement) by $461. For a child who lives part-time with the applicant, multiply $461 by the percent of time (the percent of overnights) he or she resides with applicant.

Line 21 - Enter the average monthly total of all out-of-pocket medical and remedial expenses the applicant will pay **when the case plan is in effect**. Medical and remedial expenses are those of a medical or habilitative nature resulting from the person's medical or long term care needs. Remedial expenses are medically-related and non-medical expenses for items and services needed to control or manage disabling impairments and their functional consequences.

Allowable expenses include but are not limited to:

1. Health insurance premiums (but **not** the Medicare Part B premium, which has already been accounted for by using the net Social Security payment in calculating income.)
2. Physician services, dental care, prescription drugs, hospital care, durable medical equipment (e.g., wheel chair), disposable medical supplies,(e.g., diapers, bed pads), vision care, eyeglasses/contact lenses, hearing aids and batteries, chiropractic, podiatry or any other medical service provided or prescribed by a medical practitioner licensed by Wisconsin or another state.
3. Medicare, Medicaid and other health insurance cost-sharing--deductibles, coinsurance and copayments if not accounted for in 2 above.
4. Expenses for physician recommended special diet items (to the extent they exceed the cost of a regular diet) and other physician recommended items or services needed to manage medical conditions and/or functional impairments.
5. Over the counter medications and medical supplies.
6. Ambulance costs and other transportation costs for medical purposes.
7. Reasonable and necessary remedial expenses not paid for by the long term care benefit or any required cost share, including supportive home care, respite care, transportation, case management, day care, housing modifications that increase accessibility and other medically-related items and expenses not otherwise accounted for.
8. Payments on outstanding bills for allowable medical and remedial expenses incurred prior to implementation of the care plan.

For more detail on allowable medical and remedial expenses see the attached technical assistance document used in the MA Waiver programs.

Remember: Count only expenses the applicant is expected to pay when her or his case plan is in effect. Do not count expenses a third party will pay and do not count expenses paid as part of the person's required long term care cost share.

Line 22 - Enter the monthly average of any court-ordered payments the applicant is required to make from his or her income including child support, spousal maintenance (alimony), guardianship, guardian ad-litem, or attorney fees or any other court-ordered payments. Do not include non-court ordered payments.

Line 23 -If the person is paying a cost share required by any other social or health service or program enter the total monthly amount here. **Do not enter medically related expenses reported on Line 21.**

Line 24 -If the person resides in an out of home placement, wants to return home and has a reasonable possibility of doing so in the next 12 months, up to $596 (the SSI rate) may be allowed for up to 12 months to maintain a home or apartment. Both the duration and amount allowed should be based on individual circumstances and actual costs up to the maximum. **Do not make this deduction if the person's spouse is living in the home or apartment.**

Line 25 - Personal Maintenance (or Needs) Allowance - For persons residing in a nursing home, ICF-MR, CBRF or adult family home, enter $65. For all others estimate average monthly costs for housing, food and clothing/laundry. Include in housing costs:

- Rent
- Mortgage
- Homeowner's/Renter's Insurance
- Property Tax (including special assessments)
- Utilities (heat, electricity, water, sewer, local phone service)
- Required maintenance charge (if living in a condominium or cooperative)
- Mobile home fees

Count housing costs only for the primary residence. In lieu of estimating utility costs, you may use a standard allowance as follows:

- $201 if the applicant pays heat and other utilities
- $115 if the applicant pays for utilities but not heat
- $27 if the applicant's only utility cost is telephone

Note:

- In lieu of estimating monthly food costs, the applicant may be granted a standard allowance of $127, which is the maximum food stamp allotment for one person. Do not count any cost for special foods that are on Line 21.
- In lieu of estimating actual costs for clothing/laundry, you may use a standard allowance of $45 per month.
- If estimated monthly cost of housing, food and clothing is less than or equal to $692, enter $692.
- If between $692 and $1000, enter estimated actual cost.
- If greater than $1000, enter $1000.

If the person resides with a non-applicant/recipient spouse whose gross monthly income after any allocation of income from the applicant spouse would be $1000 or more, enter $674.

Line 26 - This line totals allowable deductions from monthly resources.

Line 27 - This line subtracts allowable deductions from monthly resources to determine monthly resources available for cost sharing.

Line 28 - This line is for entering any special allowances approved by DHFS. It is to respond to unusual or unforeseeable circumstances on a case-by-case basis. Pilots should leave blank but should keep a record of situations where it might be appropriate and the amounts in question.

Line 29 - This line subtracts any special allowances. For now this should be the same as Line 27.